Approved
5/17/19
SHN

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May 16, 2019

Susan Newton, RN, BS
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of Connecticut - Department of Public Health
410 Capitol Avenue
MS# 12 FLIS P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Newton,

Attached please find our Plan of Correction for the May 3, 2019 Statement of Deficiencies for the onsite visits on January 29, February 26, 27, and March 19 concluding on April 3, 2019 by representatives of State of Connecticut, Department of Public Health.

We believe we've addressed each violation with a comprehensive plan of correction which includes all required components. Should you have any questions on the contents, please contact Cheryl Ficara, RN, MSN, Vice President of Patient Care Services at 860-545-3217.

Sincerely,

Bimal Patel
President, Hartford Hospital
Senior Vice President, Hartford HealthCare

SM:kp
Attachment(s)

DATES OF VISIT: January 29, February 26, 27, March 19 and April 3, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D3 (e) Nursing Service (1) and/or (i) General (6).

1. Based on clinical record review and interview for 1 (P#4) of 11 patients reviewed for the use of restraints the facility failed to ensure the patient was assessed according to the frequency identified in the facility policy. The findings include:
   a. Patient #5 was admitted on 1/23/19 for treatment of acute encephalopathy likely to recent surgery and narcotic use, in addition to major depressive disorder. According to the medical record on 1/24/19 at 4:53 PM an order was entered into the medical record for an enclosure/canopy bed for behaviors exhibited by P#5 such as confusion, agitation and restlessness. Alternatives such as 1:1 sitters, bed alarms and redirection were not successful in maintaining a safe environment for P#5.
   According to nursing documentation the canopy/enclosure bed arrived and was initiated on 1/24/19 at 9:00 PM as evidenced by a nursing assessment that identified an assessment of exhibited behaviors, circulation, respiratory status, range of motion and the evaluation of needs such as hygiene, fluid, meals/food and elimination.
   Although the medical record identified on 1/25/19 at 4:55 AM P#5 remains in the canopy/enclosure bed with frequent checks per protocol nursing documentation lacked evidence that P#5 was assessed for exhibited behaviors, circulation, respiratory status, range of motion and the evaluation of needs such as hygiene, fluid, meals/food and elimination on 1/24/19 at 11:00 PM and 1/ 25/19 at 1:00 AM, 3:00 AM and 5:00 AM.
   During an interview and review of the medical record with the Unit Manager and Charge Nurse on 1/29/19 at 9:00 AM they indicated P#5 should have been assessed every 2 hours while in the canopy/enclosure bed and the medical record lacked those assessments as identified.
   Hospital Restraint/Seclusion policy indicated for the use of non-violent or non-self-destructive restraints a nursing assessment is to be completed and documented every 2 hours. The assessment should include proper application of the restraint, signs of injury, physical and psychological status, hygiene, food and fluid needs, adequate circulation, range of motion, movement feeling of touch and skin integrity.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (i) General (6).

2. *Based on a review of clinical records, interviews, and policy review for one (1) of ten (10) patients reviewed for care and services (Patient #15), the facility failed to ensure that an allegation of abuse was immediately and/or thoroughly investigated and/or that the patient was free from abuse. The finding includes the following:
   a. Patient #15 was admitted on 1/9/19 with ventricular premature depolarization. The patient had a deep intraseptal paraHIsian PVC ablation completed followed by a dual chamber pacemaker implant.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Interview with RN #16 on 2/26/18 at 2:30 PM indicated that on 1/9/19 he was in the control room in the Electrophysiology (EP) lab and saw MD #15 with his hands raised to head/chest level and then MD #15 slammed his hands down on the mid abdomen of the patient. RN #16 indicated that the patient moaned.

Interview with RN #15 on 2/26/19 at 1:30 PM indicated that on 1/9/19 she had stepped out of the EP room and on her return to the control room heard a moan and asked RN #16 and 17 what the noise was, and was informed that MD #15 had just slammed his hands down on the patient and the noise was the patient moaning.

Interview with RN #17 on 2/27/19 at 10:45 AM indicated that on 1/9/19 he was in the control room of the EP lab and witnessed MD #15 slam both hands down on the magnetic mat which was on the patients abdominal area.

Interview with Scrub Tech #15 indicated that she was in the room with MD #15. ST #15 indicated that during the procedure MD #15 was holding the sheath cupped in his hands and lowered his hands to the magnetic mat. ST #15 indicated that the patient moaned.

Interview with MD #15 on 3/19/19 at 10:20 AM indicated that on 1/9/19 he performed an ablation and pacemaker insertion on Patient #15. MD #15 stated the procedure had been very lengthy and after finishing the ablation portion of the procedure, when the patient was awake, the next step was to place the patient in conscious sedation and perform the pace maker insertion. MD #15 stated that he was having a difficult time placing the guidewire and had been trying for a period of time when he realized it was not going to work. MD #15 removed the wire and sheath with two hands with the guidewire between his thumb and forefinger and upon removal, placed the sheath down with emphasis on the magnetic mat which was on the patient. MD #15 indicated that the patient grunted and the physician responded that he did not know the patient was awake. Patient #15 responded that he/she had been awake the entire time. MD #15 indicated that the patient never raised a concern or complaint following the incident. MD #15 indicated that there was no intent to harm the patient.

Interview with the Vice President of Medical Affairs (VPMA) on 2/26/19 at 12:30 PM indicated that he was notified that an internal complaint was filed regarding MD #15 and he interpreted the concern as a practitioner issue and not abuse, therefore, forwarded the concern to the Chief of Cardiology and the Chief of Electrophysiology. The VPMA indicated that no further follow-up had occurred and that the ball had been dropped.

Interview with the Chief of Electrophysiology on 2/28/19 at 2:50 PM identified that he was notified on the morning of 1/10/19 that there was a Quantros report (anonymous internal computerized reporting mechanism) regarding MD #15. He made an appointment with MD #15 for 1/15/19. At that meeting, MD #15 was notified that his reported behavior of slamming his hands down on Patient #15 was unprofessional. Another meeting with MD #15 occurred approximately two weeks later where professional behaviors were discussed.

Interview with the Chief of Cardiology on 2/26/19 at 1:11 PM identified that he met with MD #15 on 1/15/19 and discussed the incident. The Chief of Cardiology identified that he was in the process of stepping down as the Chief and thought that the in-coming Chief would be responsible for follow-up.

DATES OF VISIT: January 29, February 26, 27, March 19 and April 3, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

On 2/26/19 MD #15 voluntarily relinquished privileges at the hospital.
Review of the Medical Staff Professionalism policy failed to identify immediate actions that should occur when allegations of physical abuse are made.
Review of the Medical Staff Professionalism policy indicated communication, collegiality and collaboration are essential for the provision of safe and competent patient care. As such, all practitioners must treat others with respect, courtesy and dignity and conduct themselves in a professional cooperative manner.

The following are violations of the Regulations of Connecticut State Agencies Section19-13-D3 (e) Nursing Service (1) and/or (i) General (6).

3. Based on a review of clinical records, interview, and policy review, for two (2) of three (3) patients reviewed who utilized restraints (Patient #24 and #25), the facility failed to ensure that an assessment was conducted that warranted the use of restraints. The findings include the following:
   a. Patient #24 was admitted on 4/1/19 with an inventricular tumor. Review of a physician's order dated 4/2/19 at 5:07 PM directed the use of bilateral wrist restraints for risk for self-injury. Review of the clinical record with the Informatics RN indicated that although the patient was monitored every two hours, the record failed to reflect an assessment that warranted the use of restraints.
   b. Patient #25 was admitted to the hospital on 4/2/19 after a motor vehicle accident. The physician's order dated 4/2/19 at 6:24 PM directed the use of bilateral wrist restraints. Review of the record with the informatics RN and the Regulatory Director failed to reflect an assessment that warranted the use of restraints.
   Review of the Restraint and Seclusion Policy indicated that comprehensive assessments and reassessments should be documented in the clinical record and include in part, the following, the patient's condition, symptoms, interventions, alternatives attempted, and clinical justification (reason or behavior requiring the restraint), least restrictive devise tried and patient's response.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (i) General (6).

4. *Based on a review of the clinical record, interviews, and policy review, the facility failed to ensure that a mechanism was in place to ensure that a comprehensive investigation was completed after an allegation of patient abuse was made. The finding includes the following:
   a. Patient #15 was admitted on 1/9/19 with ventricular premature depolarization. The patient had a deep intraseptal paraHIsian PVC ablation completed followed by a dual chamber pacemaker implant.
   Interview with RN #16 on 2/26/18 at 2:30 PM indicated that on 1/9/19 he was in the control room in the Electrophysiology lab (EP) and saw MD #15 with his hands raised to head/chest level and then MD #15 slammed his hands down on the mid abdomen of the patient. RN

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

#16 indicated that the patient moaned. RN #16 indicated that no one has interviewed him about the incident.

Interview with RN #15 on 2/26/19 at 1:30 PM indicated that on 1/9/19 she had stepped out of the EP room and on her return to the control room heard a moan and asked RN #16 and #17 what the noise was, and was informed that MD #15 had just slammed his hands down on the patient and the noise was the patient moaning.

Interview with RN #17 on 2/27/19 at 10:45 AM indicated that on 1/9/19 he was in the control room of the EP lab and witnessed MD #15 slam both hands down on the magnetic mat which was on Patient #15's abdominal area. RN #17 stated that no one has interviewed him about what happened on 1/9/19.

Interview with the EP Manager on 2/26/19 at 2:00 PM indicated on 1/10/19 he received a copy of an internal report staff had filed about an incident that happened on 1/9/19 that indicated that MD #15 slammed his hands on Patient #15's abdominal area. The Manager indicated that he talked to several staff about the incident and staff reported consistent stories. However, the manager did not conduct and/or document interviews or statements.

Interview with Scrub Tech (ST) #15 indicated that she was in the room with MD #15. ST #15 indicated that during the procedure MD #15 was holding the sheath cupped in his hands and lowered his hands to the magnetic mat and the patient moaned. ST #15 indicated that no one ever interviewed her about exactly what happened.

Interview with the Assistant Manager of the EP lab on 2/26/19 at 11:50 AM indicated that the incident was reported to her on 1/10/19 by RN #17 and she spoke with him and CST #15 about the incident but did not conduct and/or document interviews or statements.

Interview with the Vice President of Medical Affairs (VPMA) on 2/26/19 at 12:30 PM indicated that the report of the incident had been forwarded to him and he had forwarded it to the Chief of Cardiology and the Chief of Electrophysiology. The VPMA indicated that after that no further follow-up had occurred and that the ball had been dropped. Additionally, the VPMA identified that if there was an issue with patient safety or if a patient was harmed, the incident would be referred to the quality department, but in this case, it was not.

Interview with the Director of Regulatory Readiness on 2/26/19 at 12:10 PM indicated that staff are able to file anonymous reports via the computer system and these are reviewed daily to determine follow-up. In this case, the report was sent to the VPMA for review.

Review of the Medical Staff Professionalism policy indicated communication, collegiality and collaboration are essential for the provision of safe and competent patient care. As such, all practitioners must treat others with respect, courtesy and dignity and conduct themselves in a professional cooperative manner. Review of Medical Staff Professionalism policy indicated that based on interviews, discussions and consultations with medical staff leaders the VPMA will determine the next course of action. Additionally the policy failed to reflect time requirements when conducting the investigation.

Hartford Hospital Plan of Correction

Unannounced visits on January 29, February 26, 27, March 19 and April 3, 2019

1, # 3:

The Restraint and Seclusion Policy was reviewed and found to be sufficient to address the standards. (4/29/19)

Documentation of restraint assessment in the electronic medical record (EMR) was reviewed and found to be sufficient to address the standards. (4/29/19)

Inpatient nurses will be re-educated on the policy requirements for nursing assessment, care planning and documentation for the use of restraints and documentation of the same in the electronic medical record. (5/10/19)

Nursing orientation curriculum related to the use of restraints will be reviewed and updated as necessary to incorporate the same policy requirements and EMR documentation elements. (5/10/19)

Monitoring of the documentation of the nursing assessment for the use of restraints will be conducted weekly on each unit with restraint episodes, May through July 2019 or ongoing depending upon performance results. (7/31/19)

The Nurse Director, Regulatory Operations is responsible for implementing the plan of correction.

2, # 4:

The Medical Staff Professionalism Policy was reviewed and will be revised to identify specific time frames for the follow-up of reports of inappropriate conduct, including: interviews of the individual who filed the report, witnesses and other staff; triage by the VPMA of the appropriate review process; review by the Department Chair; and review by the designated medical staff leaders. Despite these established time frames, the Professionalism Policy does allow for an immediate referral, at any time, of a matter being addressed through this Policy directly to the Medical Executive Committee. (5/3/19)

The revised Professionalism Policy will be presented for review and approval by the Medical Executive Committee. (5/3/19)

The revised Professionalism Policy will be communicated to Medical Staff members and Allied Health Practitioners via the VPMA Newsletter. (5/6/19)

The revised Professionalism Policy will be further reviewed with Department Chairs at the monthly VPMA Clinical Chiefs Meeting to clarify expectations of the role of medical staff leadership in investigation and follow up reports of inappropriate conduct. (5/15/19)

The Medical Staff Professionalism Policy and the Medical Staff Bylaws were reviewed to identify actions that are available to Medical Staff leadership when allegations of patient physical abuse are reported. This type of allegation is appropriately addressed under the Credentials Policy with processes in place to address concerns regarding conduct of a member of the medical staff. These processes include the ability to impose a precautionary suspension and time lines associated with that action. The Hospital or the MEC has the ability to implement the summary suspension process to "suspend or restrict all or any portion of an individual's clinical privileges or scope of practice, whenever, in their discretion, failure to take action may result in imminent danger to the health and/or safety of any individual." The investigation would then proceed within the prescribed timeline. (4/30/19)

All claims of inappropriate sexual or physical behavior by an employed staff member or member of the medical staff involving a patient, including specific allegations of patient abuse, will be monitored to ensure that a formal investigation is completed and documented per Hospital policies and/or Medical Staff policies/By-laws . (ongoing)

The VPMA is responsible for implementing this plan of correction.